DOCUMENT RESUME

ED 154 461 CS 502 110

AUTHOR Ross, F. Susan Ackerman; Sochat N.
TITLE Effect of Patients' Sex, Physicians' Attributes, and Patients' Complaint on Patients' Preference for Male vs Female Physicians.
PUB DATE Apr 78
NOTE 21p.; Paper presented at the Annual Meeting of the International Communication Association (Chicago, Illinois, April 25-29, 1978)

EDRS PRICE MF-$0.83 HC-$1.67 Plus Postage.
DESCRIPTORS Behavioral Science Research; Females; Males; *Medical Care Evaluation; Medical Services; *Patients (Persons); *Physical Examinations; *Physicians; Professional Occupations; *Sex Role

ABSTRACT

In view of the dramatic increase in the number of women graduating from medical school in each of the past five years, this study explored patients' preferences for male versus female physicians. A questionnaire was designed to determine the patients' physician preferences in regard to each of the following areas: the sex of patient; the physician attribute variables, such as nature of recommendation, availability of physician, and age of the physician; and the nature of the patients' clinical problems. Results indicate that preferences were influenced by all three experimental variables. Specifically, patients tended to prefer same-sex physicians, especially for sexual problems or those involving a thorough physical exam. Physician recommendation and physician availability variables were found to influence preferences for male rather than female physicians for both routine and potentially serious problems. (Author/MAI)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED154461

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
NATIONAL INSTITUTE OF EDUCATION

THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL NATIONAL INSTITUTE OF EDUCATION POSITION OR POLICY

Effect of Patients' Sex, Physicians' Attributes, and Patients' Complaint on Patients' Preference for Male vs. Female Physicians

F. S. Ackerman Ross (PH.D. Pennsylvania State University, 1976) is an assistant professor of Medical Education at Southern Illinois University School of Medicine with a cross-appointment to the Department of Speech Communication, Southern Illinois University, Carbondale, Illinois 62901.

N. Sochat (M.A., Illinois State University, 1974) is currently a research assistant for Southern Illinois University School of Medicine, Carbondale, Illinois 62901.

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

F.S. Ackerman Ross
N. Sochat

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC) AND USERS OF THE ERIC SYSTEM."

CS502110

Effect of Patients' Sex, Physicians' Attributes, and Patients' Complaint on Patients' Preference for Male vs. Female Physicians

There is a dearth of data on patient attitudes toward women physicians while the number of women entering medicine has increased 112% since 1971 (Gordon, 1977). Women currently comprise 20%-30% of class enrollment in many American medical schools and approximately 22% of the total application pool (McGrath & Zimet, 1977). Gordon's (1977) study of 1975-76 medical school applicants shows that of 15,365 first year students in American medical schools, 23.6% or 3,639 were women. The study further indicates a 10% increase in women medical school applicants for 1975-76 over 1974-75 though the annual rate of increase is declining. But even if the number of women applicants stabilizes, if the current rate of acceptance continues, we can expect 3500-4000 women graduates from American medical schools each year.

In addition to the increase in women medical students, there appears to be a shift in women physicians' specialty choices from previous years. For years, pediatrics was the most prevalent specialty choice among women physicians (Pennell & Renshaw, 1973), largely limiting their patient contact and treatment load to children and mothers. McGrath and Zimet (1977) indicate that family practice is now the most popular specialty choice among women physicians (44%) followed by pediatrics (25%) and internal medicine (20%). Family practice and

internal medicine provide women a greater diversity of patients (e.g., age, sex, variety of complaints, etc.) than does pediatrics.

With the increase of women physicians graduating from medical school each year and the increase in diversity of their speciality choices, there is greater opportunity for men and women patients to select or have some professional contact with a woman physician. Yet, we have limited data as to patients' attitudes toward women physicians. Thus, the present study seeks to explore patients' attitudes toward mal vs. female physicians based on patients' responses to a Physician Preference Questionnaire.

Rationale and Research Questions

Clinical medicine in this country has long been male dominated and our social reality has been constructed accordingly. That is, physicians, as healers, are permitted certain privileges of bodily access that society would otherwise define as clear rule violations, and we have constructed a social reality that legitimizes such physician intimacy. We disrobe and allow a physician to probe and manipulate our bodies as we effect a "nothing unusual is happening" stance because implicit in a medical context is the assumption that "no one is embarrassed and no one is thinking in sexual terms" (Emerson, 1970b, p. 112).

In her study of the social reality of medical contexts, Emerson (1970a) emphasizes that

> . . . because touching usually connotes personal intimacy, persons may have to work at accepting the physician's priviledged access to the patient's genitals. . . . Although most people realize that sexual responses are inappropriate, they may be unable to dismiss the sexual reaction privately and it may interfere with the conviction with which they undertake their impersonal performance (p. 76).

Thus the social reality of medical contexts is somewhat precarious. Berger and Luckmann's (1966) distinction between primary and secondary socialization seems useful for understanding the precariousness of this social reality. They point out that primary socialization is the first socialization an individual undergoes in childhood through which she/he becomes a member of society. Secondary socialization is any subsequent process that instructs an already socialized individual into new sectors of the objective world of his/her society. Thus, primary socialization teaches us that we do not casually disrobe or allow bodily manipulations by "strangers" of the opposite sex though disrobing in front of and non-sexual bodily contact with same-sex individuals is sanctioned in various contexts. Secondary socialization then teaches us that medical contexts are special settings in which it is appropriate to forgo our modesty and forfeit our bodily autonomy to physicians, as healers.

Primary socialization also teaches us that, stereotypically, males

in our society are depicted as dominant, active, strong, etc., whereas females, stereotypically, are more submissive, passive, weak, etc. (though this caricature is breaking down somewhat). Similarly, in a medical context, the physician role is defined as dominant, active, authoritative, etc., whereas the patient role is somewhat more passive, submissive, compliant, etc.

It follows that if a person is both male and physician and is seeing a male patient, no role conflict or primary socialization rules are violated. But if a person is male and physician and his patient is female, though no obvious role conflicts are created, primary socialization rules are threatened. But secondary socialization, with its rules pertaining to social reality in medical contexts, steps in and justifies such doctor/patient interactions.

However, what happens when a person is both female and physician? Working with a female patient, possible role conflicts arise though no primary socialization rules are broken; a female patient who is habituated to male physicians may have some difficulty, at first, assuming a complementary relationship with a woman physician. On the other hand, working with a male patient, not only do possible role conflicts arise but primary socialization rules are threatened. As female qua female, one is societally defined as of the less dominant and authoritative sex while her identity as physician defines her as a dominant, authority figure temporarily in charge of her male patient's body. Further, by

disrobing and probing the male patient's body, she is assuming an uncharacteristic and sexually forward role thus violating primary socialization rules. Whether the patient overtly/covertly acknowledges these physician behaviors as violations depends on the stability of the prevailing definition of the situation.

Given the significant increase in women physicians, their expanding specialty preferences with greater diversity of patient contact, and a medical social reality constructed largely for a male dominated profession, it seems relevant to question how patients will react to the influx of women physicians. More specifically, this study was designed to shed light on the following questions: (1) Does sex of patient influence preference for male vs. female physicians? (2) Do patients' physician preferences vary depending upon certain physician attributes unrelated to physician gender, and (3) Do such patient preferences vary as a function of the nature of the patients' clinical complaints?

Method

Design

The present study was designed to investigate patient preferences for male vs. female physicians as a function of three variables: (1) sex of patient, (2) attribute variables of the physician, and (3) the nature of the patients' clinical complaints. Physician attribute variables included situations in which the male and female physician were described as differing in regard to: (1) strength of recommendation,

(2) earliest availability of appointment, and (3) age of physician. An additional factor, used to establish a control condition, provided no physician attribute information. The patients' presenting clinical complaints included four medical problems of varying degrees of seriousness and intimacy. They included: (1) severe sore throat and fever, (2) a thorough physical exam, (3) consultation and examination pertaining to a sexual problem, and (4) blood in one's urine.

A Physician Preference Questionnaire was designed which included eight sets of Physician Attribute Variables each of which subsumed four Clinical Complaint Variables. Responses to all possible combinations of Physician Attributes and Clinical Complaints were obtained from each participant yielding a total of 32 separate items. Participants indicated their preferences for either male or female physicians by selecting appropriate response categories on a 5-point Likert-type scale.

The analysis of data implied mixed analysis of variance designs in which physician attributes and patient clinical complaints served as the within-subject variables and patient sex as the between-subject variable.

Subjects

Participants were drawn from four population pools: (1) undergraduate students enrolled in a beginning communication course at _____ University, (2) simulated patients participating in a diagnostic interviewing program with first year medical students, (3) Ph.D. faculty at _____ University Medical School--

_____, and (4) faculty members in the Speech Communication Department at _____ University.

Preliminary comparisons of the responses of these four population pools yielded significances on only a small number of items. Thus, in subsequent analyses, the four groups were combined producing a total sample of 68 participants.

Questionnaires headed "Physician Preference Questionnaire" were distributed to all members of the above four groups with a cover letter requesting that they complete and return it anonymously indicating only their age, sex, and group identification. Eighty-six questionnaires were distributed and 68 or approximately 80% of those distributed were returned. Returned questionnaires included 35 males and 33 females with a combined mean age of 33 years. All participation was voluntary.

Materials

The Physician Preference Questionnaire included eight sets of Physician Attribute Variables each of which subsumed the four patient Clinical Complaint Variables. For each clinical complaint in each set, participants were asked to indicate their physician preference on a 5-point Likert-type scale which was scaled as follows: "5" strongly prefer female; "4" slightly prefer female; "3" no preference; "2" slightly prefer male; "1" strongly prefer male.

Physician Attribute Variables. The eight sets of physician

variables included:

Set I Assume that both the male and female physician are highly recommended to you and both can see you immediately.

Set II Assume that the male physician is highly recommended while you know little about the female physician other than one of your neighbor's friends goes to her.

Set III Reverse of Set II.

Set IV Assume that you know nothing about the qualifications of either physician. You received only their names from a vague acquaintance (control condition).

Set V Assume that the female physician can see you immediately while the male physician cannot see you for a week.

Set VI Reverse of Set V.

Set VII Assume that the male physician is middle-age (40's -50's) and the female physician is in her early 30's.

Set VIII Reverse of Set VII.

Clinical Complaint Variables. The four Clinical Complaint items included under each of the eight Physician Attribute sets were:

1. You have a temperature of 102° and a severe sore throat, so severe that you can barely swallow solids or liquids.

2. You need a thorough physical examination as part of the insurance/entrance requirements for the new job/school to which you are applying.
3. You are having a sexual problem and want some sexual counseling and a genital/gynocological exam.
4. You have noticed blood in your urine for the past two days.

Results

Means were tabulated for male and female respondents separately for each of the 32 items and compared via *t* tests for independent samples (see Table 1).

Insert Table 1 about here

Results suggest that of the four clinical items, Complaint 3 (sexual problem), elicited the most polarity between male and female participants. Regardless of physician attributes (e.g., recommendation, availability, age, etc.), participants indicated preference for a same-sex physician across all eight conditions for Complaint 3 ($p < .001$) with a male $M = 2.14$ and a female $M = 3.72$. Inspection of means suggests that Complaint 2 (physical exam) was second strongest in differentiating between male and female preferences (male $M = 2.39$ and female $M = 3.29$). Male vs. female responses on seven out of eight sets for Complaint 2 were

statistically significant. Set VI (male can see you immediately and female cannot see you for a week) was the exception (male $\underline{M}$ = 1.69 and female $\underline{M}$ = 2.06).

"No Preference" responses were tabulated for each of the four clinical complaint items across the eight physician attribute sets. There were 53 or 66%-80% fewer "No Preference" selections for Complaint 3 (sexual problem) than for the other three clinical complaints. "Sore throat" had the most "No Preference" selections ($\underline{f}$ = 205) and also tended to elicit the least polarity between male ($\underline{M}$ = 3.06) and female ($\underline{M}$ = 3.08) participants.

Based on preliminary findings, five subsequent analyses were conducted. The first four compared the preferences of male and female participants across scaled categories of physician attribute sets. Scores were determined by summing each participant's responses over the four clinical complaint items. The last analysis compared male and female responses across each of the four clinical complaint items; scores were determined by summing each participant's response over the eight physician attribute sets.

Analysis 1: Control Condition

A one-way ANOVA was conducted to assess preference for male vs. female physicians given no supplementary information about either physician. The analysis yielded a statistically significant effect due to patient sex, $\underline{p} < .001$, indicating a tendency for male and female

patients to prefer physicians of their own sex (male M = 2.62 and female M = 3.34). Recognizing that responses were made in the absence of descriptive information concerning physician attributes, the above means, in essence, establish informal baselines for interpreting preferences indicated in the other physician attribute conditions.

Analysis 2: Sex by Recommendation

A two-way ANOVA was conducted in which the factors were patient sex and three physician recommendation conditions (e.g., male highly recommended, female highly recommended, both highly recommended). Both main effects were found to be significant. The effect due to sex ($p < .001$) cooroborated the finding for the control condition by showing the male mean (M = 2.56) to be closer to the male end of the physician preference continuum than the female mean (M = 3.32). The significant recommendation effect reflected a tendency for both sexes to vary the degree of their preferences depending upon which physician was more highly recommended. Specifically, when the male was more highly recommended, male M = 1.71 and female M = 2.56; when the female was more highly recommended, male M = 3.46 and female M = 4.25; when both were equally highly recommended, male M = 2.51 and female M = 3.43. The failure to obtain a significant sex by recommendation effect ($p > .05$) suggests that the degree of these preference shifts was generally comparable for the two sexes.

Analysis 3: Sex by Availability

This analysis included a 2 x 2 ANOVA, consisting of sex of respondent and two conditions of physician availability (e.g., female can see you immediately and male cannot see you for a week and the reverse). Again, results indicated a statistically significant difference between male (M = 2.7) and female (M = 3.3) responses, $p < .001$ across the two conditions. The significant main effect due to availability suggests that preferences shifted toward the male end of the continuum when the male physician was described as available (male M = 1.44 and female M = 2.01) and more toward the female end when the female physician was described as available (male M = 3.97 and female M = 4.61). The two-way interaction was not found to be significant ($p > .05$).

Analysis 4: Sex by Age

A 2 x 2 ANOVA was conducted to assess the effects of patient sex and physician age on patients' physician preferences. (Note that 15 participants were dropped from this analysis due to the inavailability of the age items at the time these participants completed the questionnaire.) The analysis yielded a significant main effect due to sex, $p < .001$. Regardless of physician age, participants indicated a preference for a physician of their same sex (male M = 2.57 and female M = 3.29). The main effect due to physician age was not significant nor was the interaction between sex and age (p's > .05).

Analysis 5: Sex by Complaint

The last analysis was a 2 x 4 ANOVA consisting of sex of respondent and the four presenting clinical complaints (sore throat, physical exam, sexual problem, blood in urine). As in all previous analyses, sex of participant was found to be a significant determinant of physician preference, $p < .001$. Specifically, males ($M = 2.78$) exhibited a stronger preference for treatment by a male physician than did females ($M = 3.33$). Although preferences did not significantly differ across the four clinical complaints ($p > .05$), the interaction between sex and complaints was significant ($p < .001$).

Inspection of the means comprising the interaction suggests that the greatest polarization between male and female respondents occurred for clinical Complaint 3, the sexual problem; both sexes shifted considerably toward a same-sex physician. Complaint 2, thorough physical exam, also produced considerable polarity; males ($M = 2.39$) shifted toward the male end of the continuum and females ($M = 3.29$) shifted toward the female end. In contrast, there appeared to be relatively little difference between male and female preference scores when the clinical complaint was a sore throat (male $M = 3.06$ and the female $M = 3.08$).

Discussion

Results of this study indicate that preference for male vs. female physicians is influenced by all three experimental factors: sex of

patient, nature of the clinical complaint, and specified physician attributes. Responses suggest a unilateral preference for same-sex physicians on all but a few items (male total $\underline{M}$ = 2.60 and female total $\underline{M}$ = 3.33).

The few instances in which males preferred female physicians included the following conditions: (1) When the female physician was more highly recommended than the male. (Note that for Complaint 3, each respondent indicated a same-sex physician preference for sexual problems.) (2) When the female physician was immediately available and the male was not. (Note that for Complaint 3, males indicated a "no preference" tendency.) (3) When the clinical complaint was a sore throat. In this instance, male scores tended slightly toward the female end of the continuum provided that (a) both physicians were equally highly recommended, (b) no additional information was provided for either physician, or (c) the female was in her early 30's. Responses suggesting female preference for male physicians included the following conditions: (1) The male physician was more highly recommended than the female. Complaint 3 was again the exception. (2) The male physician was immediately available and the female was not. Here females indicated a "no preference" tendency for Complaint 3. Thus, physician attributes of "strength of recommendation" and "availability" seem to significantly affect patients' physician preferences, regardless of the physician's gender, except when the clinical problem is of a sexual nature.

Looking at clinical complaint items, complaints of a seemingly routine, non-intimate nature (e.g., sore throat) elicited no significant differences between male and female responses. One may speculate that when no primary socialization rules are broken, the prevailing social reality holds and gender of physician is not a strong preference variable.

When the clinical complaint involved disrobing and potential bodily probing (e.g., physical exam), there was significant polarity between male and female preferences across the item (male $\underline{M}$ = 2.39 and female $\underline{M}$ = 3.29). These results lead one to speculate that despite secondary socialization, the patient is aware of physician gender and prefers to disrobe and be examined by a same-sex physician. Further, males' responses indicated a slightly stronger same-sex preference than indicated by females. Perhaps a habituation-to-male-physicians factor was operating.

Greatest polarity between male and female responses was across Complaint 3, sexual problem. Neither males nor females indicated a preference for a physician of the opposite sex on any of the eight experimental sets across Complaint 3. For this item, clinical complaint and patients' sex clearly affected patients' preference for a male vs. female physician. Primary socialization factors plus empathy or identification factors may all have been operating here.

The potential seriousness of "blood in urine" might lead to

speculations that physician variables of "recommendation" and "availability" would be stronger preference factors than physician sex. Results confirm this, though males did not shift as strongly toward the female end of the continuum for the recommendation and availability sets as did females. Conversely, females did not shift as strongly toward the male end of the continuum for these two physician sets as did males. Thus the sex of physician variable did have some effect on patients' physician preference for Complaint 4, though it did not appear to exert the strongest influence.

It seems warranted to conclude that female patients would both accept and oftentimes prefer a female physician. For problems of a sexual nature or involving a thorough physical exam, females prefer a female physician and thus, there is a need for women physicians in such specialty areas as obstetrics and gynecology, internal medicine, etc. Male patients indicated a reluctance to be treated by female physicians, particularly for sexual problems or those involving a thorough physical exam. Thus in settings such as public clinics and V.A. Hospitals, where male patients may be randomly assigned a female physician, attention to communication techniques and physician willingness to acknowledge, "something unusual is happening," may alleviate some potential patient uncomfortableness. Finally, for problems of either a routine (sore throat) or potentially serious (blood in urine) nature, factors other than physician sex (e.g., recommendation, availability, etc.) seem to be

the more salient variables affecting patients' physician preferences. In such instances, both male and female patients seem willing to be treated by a highly recommended and available female physician.

References

Berger, Peter L., & Luckmann, Thomas. The social construction of reality. New York: Doubleday & Company, 1966.

Emerson, Joan P. Behavior in private places: Sustaining definitions of reality in gynocological examinations. In Hans Peter Dreitzel (Ed.) Recent sociology No. 2: Patterns of communicative behavior. New York: Macmillan Co., 1970a, 73-97.

Emerson, Joan P. Nothing unusual is happening. In Tamotsu Shibutani (Ed.) Human nature and collective behavior: Papers in honor of Herbert Blower. Englewood Cliffs, N.J.: Prentice-Hall, 1970b, p. 212.

Gordon, Travis L. Descriptive study of medical school applicants, 1975-76. Association of American Medical Colleges. (Tech. Rep. 231-76-0011.) Washington, D.C. February, 1977.

McGrath, Ellen, & Zimet, Carl N. Female and male medical students: Differences in specialty choice selection and personality. Journal of Medical Education, 1977, 52, 293-300.

Pennell, M. Y., & Renshaw, J. E. Distribution of women physicians. Journal of American Medical Women's Association, 1973, 28, 181-186.

Table 1

Mean Preference Scores by Male and Female Patients on Each Questionnaire Item

	Physician Attributes								
	Both Recommended	Male Recommended	Female Recommended	No Information	Male Available	Female Available	Male[a] Middle Age	Female Middle Age	Row Means
Sore Throat									
Male	3.06	2.00	4.09	3.09	1.46	4.77	3.21	2.79	3.06
Female	3.12	2.24	4.06	3.09	1.36	4.67	2.96	3.16	3.08
Physical Exam									
Male	2.26	1.44	3.20	2.51	1.69	3.69	2.17	1.50	2.39
Female	3.36***	2.42**	4.24***	3.21***	2.06	4.55**	3.32*	3.12**	3.29
Sexual Problem									
Male	2.06	1.37	2.77	2.14	1.37	2.94	2.46	2.04	2.14
Female	2.94***	3.09***	4.52***	3.82***	3.00***	4.55***	3.60**	3.64***	3.72
Blood in Urine									
Male	2.69	1.71	3.77	2.74	1.23	4.49	2.93	2.50	2.76
Female	2.30*	2.48**	4.18	3.24*	1.61	4.67	3.16	3.32***	3.25
Row Means									
Male	2.51	1.71	3.46	2.62	1.44	3.97	2.69	2.46	2.60
Female	3.30	2.48	4.18	3.24	1.61	4.67	3.16	3.32	3.33

NOTE: Significant differences between male and female means are indicated by asterisk(s) adjacent to female means for each item.

[a]15 participants did not complete Physician Attribute Sets VII and VIII. Means were computed on the basis of n=53.

*p .05

**p .01

***p .001